

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012288	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 03/17/2015
NAME OF PROVIDER OR SUPPLIER LAMPLIGHT INN OF FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP CODE 300 E WASHINGTON BLVD FORT WAYNE, IN 46802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00165118 completed on 2-10-2015.</p> <p>This visit was in conjunction with the a Post Survey Revisit (PSR) to the PSR completed on 12-22-2014 to the Investigation of Complaint IN00158196 completed on 10-31-2014.</p> <p>Survey dates: March 16, and 17, 2015</p> <p>Facility number: 012288 Provider number: 012288</p> <p>Survey team: Christine Fodrea, RN, TC Angela Strass, RN</p> <p>Census bed type: Residential: 134 NCC: 10 Total: 144</p> <p>Census payor type: Medicaid: 97 Other: 47 Total: 144</p> <p>Sample: 5</p> <p>Lamplight Inn was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the Investigation of Complaint IN00165118.</p> <p>Quality review completed on March 17, 2015 by Randy Fry RN.</p>	{R 000}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE